

Dispensed by Manitoba Pharmaceutical Association (MPHA) Member, Nexus
Licence # 32533

/ 1515 One Lombard Place / Winnipeg / Canada / R3B 0X3
/ Phone (toll-free) 1.877.592.9192 / Fax (toll-free) 1.877.737.3517
/ email: info@discountrxmart.com / web: www.discountrxmart.com

If you have previously filled out a questionnaire, please indicate if there are any changes: Y N First Questionnaire

Contact Information (please print clearly)

First Name _____ >PDP5
Last Name _____
Date _____
Address _____
City/Town _____
Email _____
Phone (home) _____
Phone (work) _____
State _____
Zip _____
Primary Physician Name _____
Address _____
Phone _____

Additional Information

Age _____
Height _____
Weight _____
Sex M F
Date of Birth (DMY) _____

Regular Exercise Y N
Do you smoke cigarettes? Y N
Do you drink alcohol? Y N

If yes to either of the above, what type, frequency and duration. Please indicate in the space below.

Important

Please note It is mandatory to have had a physical examination in the last 12 months to apply for a consultation.

Have you had one? Y N

Patient Family History

1) Diabetes, thyroid or other endocrine disorder Y N
2) Breast cancer Y N
3) Hypertension (high blood pressure) Y N
4) Cardiovascular (heart or artery disease) Y N
5) Lipid (cholesterol) disorder Y N
6) Prostate Cancer Y N
7) Other forms of cancer Y N
8) Migraine Headaches Y N
9) Other illness not previously noted _____

Patient Questionnaire

Please complete and fax this form
toll-free 1.877.737.3517

Patient Medical History

1) Blood disorders Y N
2) Cancer Y N
3) Immune disorders Y N
4) Poor wound healing Y N
5) Edema or excessive fluid retention Y N
6) Neurological disorders (stroke, Parkinsons, Alzheimers, etc.) Y N
7) Thyroid, diabetes or other endocrine disorder, including insulin resistance Y N
8) Any known nutrition deficiency including minerals and electrolytes Y N
9) Hyperlipidemia (high cholesterol) Y N
10) Upper respiratory disorders Y N
11) Lung disorder (i.e., asthma, emphysema) Y N
12) High blood pressure Y N
13) Heart disease including arteriosclerosis, angina, heart failure or history of heart attack Y N
14) Renal or kidney disease Y N
15) Liver disease Y N
16) Drug allergies Y N
17) Orthopedic or muscle disorder, including fracture, joint disorder or carpal tunnel syndrome Y N
18) Emotional disorders Y N
19) Surgery Y N
20) Glaucoma Y N
21) Medications used in the last 12 months Y N
If yes, please specify _____

22) Rheumatoid arthritis, lupus, or connective tissue diseases Y N
23) Gastrointestinal Problems (stomach, ulcers, pancreatitis, etc.) Y N

If you answered yes to any of the previous questions please elaborate in the space below (i.e, duration of illness, any treatment or surgery received, amount smoked and for how long.) Please list all medications you are currently using, including the dosage and frequency.

The following disclaimer is an integral part of this patient questionnaire:
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Print Name _____
Signature _____
Date _____

toll-free 1.877.592.9192
 toll-free fax 1.877.737.3517

For pharmacy use only - tracking number
PDP5

Prescription Product Order Form

Please complete and fax this form toll-free 1.877.737.3517

DiscountRxMart
 LOW COST CANADIAN MEDICAL SOLUTIONS

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First Name _____ >PDP5
 Last Name _____
 Address _____
 City/Town _____
 State _____
 Zip Code _____
 Country _____
 Phone (home) _____
 Phone (work) _____
 Email _____
 Payment Type Visa Mastercard Other (see below)*
 Name on Card _____
 Card Number _____
 Expiry Date _____
 Shipping Information: Same as above? Yes No If no
 Name _____
 Address _____
 City/Town _____ State _____
 Zip Code _____ Country _____
 Phone _____
 Email _____

Please do not forget these important questions:

- Is this a Refill?
 Y N
 If yes, Refill number: _____
- Have you previously filled out a Patient Questionnaire form?
 Y N
 If no, please fill out and submit Patient Questionnaire form with your order.
- Do you want your order shipped with another family member's at your same address?
 Y N
 If yes, name: _____
- Do you understand and agree that we will use generics to fill orders and save you money unless prescription specifies brand only?
 Y N

	Drug Name	Strength	Quantity	Price	

**We accept "International" money orders available at any U.S. Post Office or bank. Attach money order to your Prescription Product Order form. If this form of payment is chosen, all forms must be mailed, not faxed. Please allow an additional 7 days processing due to mail time.*

Sub Total	
Shipping	\$15.00
Total	

Don't forget to:

- Attach the original prescription or Fax a copy of your prescription or have your doctor call
- Attach a void check if choosing electronic check payment option